Remarks of
CONGRESSMAN HENRY A. WAXMAN

to the
LOS ANGELES RADIOLOGICAL SOCIETY
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I'm glad to be able to join you today to talk about some key health-related concerns Congress will face this session.

For the first time in many years, health care is one of the most prominent issues in the public mind, and the opportunity for change many finally be upon us. This is a timely meeting; this is a period of great discontent about America's health care system, and a time when Washington is filled with discussion about what to do to respond.

As you know, I chair the House subcommittee with primary responsibility for Federal health programs, and the range of issues we work on is broad. This year we will:

* continue to fight the battle to save family planning programs from the conservative strait-jacket that would stop a doctor from even talking to a patient about what her medical options are;

* we will work to lift the ban on NIH research using fetal tissue, research that has the potential to find cures and treatments for diseases like Parkinson's, diabetes, and Alzheimers. Rather than acknowledging that abortion exists and using the fetal tissue in the same way as one would use an organ for transplant, the NIH is forbidden even to study this field;

* and we hope to see enactment of legislation that will reduce toxic exposure to lead, the number one environmental health threat to children in America. This legislation will provide for lead screening programs and reduce the possibility of lead contamination through drinking water, paint, soils and food.

While these issues are the bread and butter of my Subcommittee's work, today I'd like to focus my remarks on two issues of major concern to you right now: the on-going changes in Medicare policy, and the prospects for health care reform.

Too often in Washington, the sad fact is that most of the health care fights have nothing to do with health care policy -- they have to do with money. The battles are about budgets and deficits and financing schemes and taxes. And just as often, the debaters forget about doctors and hospitals and patients and disease.

While the Bush Administration has brought in the kinder and gentler rhetoric, this rhetoric masks a Reagan-like, budget-driven health agenda that divides services from payment, and pits payors against providers.

Medicare

Once again, the Bush Administration seems determined to use the Medicare program as a primary source for budget savings. Despite a 5-year budget agreement in 1990 calling for Medicare cuts of $42 billion, the President obviously thinks the program is ripe for further reductions.

In the President's State of the Union address on Tuesday -- and in his subsequent budget submission -- he recommends a Fiscal Year 1993 cut in Medicare of $1.2 billion. For the most part, these savings would come from increases in out-of pocket costs for beneficiaries and cuts in payments for anesthesia, laboratory and durable medical equipment items. In addition, the President would like to impose user fees on hospitals and others to cover the costs of determining compliance with Medicare's Conditions of Participation.

I can see no coherent health policy behind this disparate collection of proposals. I can only conclude that this budget is just a continuation of the blind, arbitrary budget-driven policies that have characterized the past 12 years of the Reagan-Bush Administrations.

What is especially disturbing is the likelihood that additional Medicare reductions will be proposed by the President next month in order to pay for his wrong-headed notion of tax credits to buy health insurance -- more about that in a minute.

Equally disappointing is the absence of any proposals to improve benefits or limit the rapidly rising costs of care faced by the elderly and disabled. The cost-effectiveness of preventive services has been well documented, and yet many of these services are still not covered by Medicare. Outpatient prescription drugs are also a steeply rising out-of-pocket cost for the elderly, particularly those who are unable to afford private supplementary insurance or are not poor enough for Medicaid eligibility. Nothing in the President's budget addresses these shortcomings in Medicare.

As you all know, these budget proposals come on the heels of last year's attempt to use the new Medicare Fee Schedule as a device for cost-cutting. After working long and hard with the physician and beneficiary communities to reach agreement on a budget-neutral fee schedule, we had to spend considerable time last year making sure that the Administration followed congressional intent.

I was outraged, as you were, that last year's proposed rule from HHS so clearly ignored both the letter and spirit of the agreement on physician payment reform.

Particularly disturbing to me is the damage to the credibility of the Federal government that results from such a willful disregard of both congressional intent and the clear understanding Congress had with providers when the reforms were enacted. It is never easy or painless to engage in fundamental policy reforms -- as we are seeing in the unfolding debate on health reform. In this case, Congress, physicians, and the beneficiary community made significant compromises with the expectation that the final

agreement would be fairly implemented and that both the Nation's elderly and disabled and physicians would be better served.

I want to particularly recognize the constructive participation of the radiology community in working with Congress and the Administration in the development of a fee schedule for your services. I am sure that many of you are wondering now whether your early involvement in this process -- going back to 1987 when the American College of Radiology worked with me and others to move toward a fee schedule for radiology -- whether this was a wise move. I recognize that the cumulative effects of budget cuts over the last four years and other features of the new RB-RVS fee schedule have resulted in significant reductions in Medicare radiology payments.

Let me assure you that I intend to monitor carefully the impact of the fee schedule and to consider further refinements to assure physicians are treated fairly. One area that certainly merits further review is whether the fee schedule adequately recognizes the costs of practice that physicians face. You probably know that practice costs have not been treated in the same manner as the value of phyicians' work, and this is especially important to radiologists. We are looking at recommendations from the Physician Payment Review Commission about how to improve the accuracy and fairness of practice cost adjustments.

While the pressure put on the Administration last year by the Congress and the provider community caused them to moderate their action slightly, it was clearly not enough. And the great frustration the Congress then faced---and here's that problem with the budget driving policy again---is that to enact legislation to force HCFA back to the policy we originally intended was estimated to cost billions of dollars. So it couldn't be done without breaking that ill-conceived budget agreement or covering the costs by cutting Medicare elsewhere.

Meanwhile, I want you to know that I am committed to further improvements in Medicare, especially to expand coverage for cost-effective preventive services, and to provide coverage for prescription drugs -- as I stated earlier. It will not be easy to find the resources for these initiatives, but I believe the failure of Medicare to provide coverage of preventive services costs us much more than the dollars necessary to pay for these benefits.

Our Subcommittee will also be working to extend the authority for the Agency for Health Care Policy and Research.

This Agency -- the focal point of the federal government's efforts to support research on medical effectiveness and patient outcomes -- is a critical part of the physician payment reforms enacted in 1989. It is the agency responsible for working with physicians and other health professionals in the development and dissemination of clinical practice guidelines.

In these times of tight budgets, it is even more important to have good information about what works best in medical care, and what services provide little benefit to patients. Otherwise, we are likely to be forced into arbitrary, budget-driven policies that interfere with physician judgement and deny patients medically appropriate care.

As we review the Agency's work to date, we will need your advice about the research agenda and how best to interpret and apply research findings. Obviously, it's critical that these activities enjoy the support of practicing physicians and those who depend on Medicare to finance their care.

Health Care Reform

Finally, let me discuss briefly with you the current state of discussions on health care reform. I think we can all agree that our health financing system has some serious problems:

* Big companies pay more for their employees' health care to cross-subsidize the bad debt of others;

* Small companies can't buy an affordable plan that isn't riddled with exclusions and limited in scope;

* Individuals can, in essence, only get insurance against surprise injuries, not against predictable illness;

* Medicaid fails to cover many of the poor, and pays badly for those it does cover;

* Medicare is overwhelmed with cutbacks and loopholes;

* And 33 million Americans have none of the above and depend on emergency rooms and charity to get any health care at all.

It's a disgrace--and that's clear all across America, from small businesses to Fortune 500 companies, from those people paying high premiums to those who have lost their health insurance.

In my judgement, our health financing system is on a self-destructive path. The structural problems are <u>not</u> self-correcting. If nothing is done, things will just get worse. In just 5 years, it is estimated that employers who provide health benefits will, on average, spend about 17 percent of their payroll for health insurance -- up from an average of 11 percent today.

Even the Bush Administration has -- belatedly -- come to the realization that the status quo is not an option. They know that, at least in an election year, you can't tell people there is no need to address such a pressing concern.

Details of the Administration's plans are expected early next month, but some parts of it have already been revealed in the State of the Union address last Tuesday. Apparently, the President has decided to propose tax credits for individuals currently without health benefit protection. In addition, it is expected that he will call for small market insurance reforms, and malpractice tort reforms. Some have speculated that tax credits could cost as much as $150 billion over 5 years in lost tax revenues.

While I am encouraged by the President's new found interest in health reform, these proposals would -- in my judgement -- fall far short of our goals for health reform. Tax credits of $3700 per year would likely represent less than half of the cost of basic health plans. Since the credits would only be available to very low-income individuals who currently have no job-based benefits, it's hard to imagine that many of the 34 million uninsured would find coverage affordable.

Moreover, without any effective cost containment, the cost of benefit plans will continue to soar, and millions more Americans will likely find themselves and their families without coverage.

In short, tax credits alone would do little to expand health benefit protection or make coverage more affordable. It's even possible that credits might encourage employers who currently provide coverage to drop it in order to make workers eligible for the credits. And, lastly, relying on individual purchase of health benefits has proved to be the most costly and inefficient means for providing health insurance.

Without universal coverage and effective cost containment, meaningful health reform is not possible. Universal means coverage regardless of employment status or income. It means continuous coverage, and a more equitable and predictable distribution of the costs of care.

In Congress, the debate on health care reform has begun in earnest. A key Senate committee last week approved a reform bill introduced by Majority Leader George Mitchell. In the House, a variety of bills have been introduced, including proposals for a single payer program, and bills -- like my own and Chairman Rostenkowski's -- that build on job-based private coverage supplemented by a strong public plan.

The measure I have introduced is based on the recommendations of the Pepper Commission on which I served two years ago. Under it, all Americans would be covered for basic health benefits in one of three ways:

1. Employers would be responsible for providing basic coverage to their employees and dependents. Employers could offer this coverage privately, or

2. they could enroll their workers in a new Medicare-like public plan for a premium set at a percent of payroll. This program would also cover those people outside the workforce;

3. And in the case of the elderly, continued coverage through Medicare.

More than 150 million Americans currently have basic health benefits through employment-based plans. My bill strengthens this model by offering employers powerful new tools to help make benefits more widely available and to control the spiraling cost of coverage.

Private health plans would be subject to federal requirements that prohibit the exclusion of persons from coverage on the basis of individual health status. Insurance pricing practices in the small employer group market would also be subject to federal standards based on community rating methods.

For those Americans outside the workforce, including those eligible for Medicaid, access to basic benefits would be provided through a new public program which -- like Medicare -- would be uniform and administered by the Federal government, and -- unlike Medicaid -- would not be tied to the welfare system. Medicare would continue to serve the elderly and the disabled.

The bill also includes the cost control features recommended by the Pepper Commission such as expanded opportunities for managed care, cost-sharing for basic services, and support for the development and use of clinical practice guidelines. In addition, private plans would be given the option to use provider payment rates established for the public plan to help control the costs of care.

Financing would be based on a combination of existing employer and worker contributions, and additional federal revenues from an income tax surcharge to cover the costs of including Medicaid eligibles and the unemployed in the new public plan.

I recognize that this is an ambitious proposal and that alternative, comprehensive plans supported by other Members have much to recommend them. I have chosen this course because I believe it is the least disruptive, and has the potential for broad public support. In addition, I am committed to a federally-financed public plan that is <u>not</u> linked to welfare and provides access to quality care those outside the workforce.

I also am anxious to support reforms in the administration of health benefits that reduce the complexity and burden of our current multi-payer system. I believe that many of the efficiencies associated with single payer systems -- simplified billing and payment forms and consolidated claims administration -- can be incorporated into a scheme that permits multiple health benefit plans.

The solutions to these problems will not come easily or quickly. Any meaningful reform will change the way we finance health care services, and many of us will face additional burdens. But, as we consider the costs of change, we must recognize the even larger costs to our society if we fail to act. Every day that we delay, more Americans go without needed care and the costs of services push insurance coverage beyond the means of more working people and their families. Waiting will not make these problems easier or cheaper to solve.

I hope we can work with the White House in fashioning a comprehensive plan that meets our reform goals. Surely we can find a way to end the disgrace of millions of Americans without access to decent, affordable health care.

I look forward to your help and advice. And, I thank you for the chance to talk with you about these critical issues.